



328 10 Street N.W.
Calgary, AB T2N 1V8
(403) 237-6866
www.effectivehealth.ca

Therapist: _____

MASSAGE THERAPY

Name: _____
(First) (Initial) (Last)

Address: _____
(Street) (City) (Postal Code)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Email Address: _____

Date of Birth: _____ Age: _____ Male Female
(Month/Day/Year)

How did you find out about our clinic? _____

If referred, please provide name of referee (so we can thank them): _____

Would you like to receive the clinic e-mail newsletter? Yes No

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Family Doctor: _____
(Given) (Surname)

Treating Doctor: _____ Phone: _____
(Given) (Surname)

Please circle if a current problem exists **OR underline** if it was a past problem:

MUSCULOSKELETAL

- Bone or joint disease
- Tendonitis/Bursitis
- Jaw pain/TMJ
- Broken/fractured bones
- Arthritis
- Sprains/Strains
- Low back/hip/leg pain
- Neck/shoulder/arm pain
- Headaches/head injuries
- Spasms
- Fibromyalgia
- Flat feet/high arches

CIRCULATORY

- Heart condition
- Varicose veins
- Blood clots
- High/low blood pressure
- Lymph edema

GENITO-URINARY

- Pregnant
- PMS
- Menopause
- Frequent urination
- Kidney infection
- Prostate trouble

SKIN

- Dryness
- Bruise easily
- Rashes
- Athletes foot
- Warts

NERVOUS SYSTEM

- Numbness/tingling
- Chronic pain
- Herpes/shingles
- Fatigue
- Sleep disorder
- Multiple Sclerosis

DIGESTIVE

- Constipation
- Diarrhea
- Gas/bloating
- Irritable bowel syndrome

RESPIRATORY

- Chest pain
- Chronic cough
- Asthma/Allergies
- Difficulty breathing
- Ear aches

Infectious or Communicable Diseases

Please list: _____

Other:	Cancer/tumors	Mental health condition
	Nicotine	Poor nutrition
	Caffeine	Drug/alcohol problems

Medical History

Main Concern: _____

Current Medications: _____

History (include description and dates):

Surgeries: _____

Accidents: _____

Date of Last Massage: _____

MESSAGE CARE AGREEMENT

Each person must sign this document before any treatment is rendered.

My signature acknowledges that:

I have been informed that Effective Health Solutions is the management company providing management services to the individual practitioners at the clinic. I further acknowledge that Effective Health Solutions, its directors, officers and employees shall not be liable for any loss, cost, damage and expense which I may suffer, sustain, pay or incur, whatsoever or however caused, arising directly or indirectly, as a result of or in connection with my treatment at the clinic.

INFORMED CONSENT TO MASSAGE THERAPY AND CARE

I understand that massage is given here for the purpose of stress reduction, relief from muscular tension, spasm or pain, and improving blood circulation to the muscles. I understand that the Massage Therapist does not diagnose illnesses, disease, or any physical or mental disorder. As such, he/she does not prescribe medical treatment or pharmaceutical, nor does he/she perform spinal manipulations. It has been made clear to me that massage is not a substitute for medical examination or diagnoses and that it is recommended that I see a Physician for any ailment that I may have. I will state all my known medical conditions and take it upon myself to keep the Massage Therapist updated on my physical health. I hereby request and consent to the performance of massage therapy.

Consent for Liability for Cost

I hereby acknowledge and understand my liability of any costs incurred by myself at this office.

Consent for Treatment

I hereby authorize and grant permission to my Massage Therapist to carry out such examinations, procedures and treatment as deemed necessary.

I acknowledge that this form has been explained to me and that I fully understand the contents of this form and its implications.

Patient's Name: _____

Patient's Signature: X _____ **Date:** _____
(If you are under 18 years of age, a parent or guardian must sign this form)

OR

Guardian's Signature: X _____ **Date:** _____